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PERSPECTIVE

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Misunderstandings and ambiguities in strategic purchasing in low- and middle-income countries

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Summary

Strategic purchasing is branded as an approach that is necessary for progress towards universal health coverage. While we agree that publicly purchased health services should respond to society's needs and patient expectations, and thus generally endorse strategic purchasing, here we would like to explore two emerging concerns within current discussions in low- and middle-income countries. First, there exists a great deal of misunderstanding and conceptual unclarity, within practitioner groups, around the concept of strategic purchasing and what instruments it incorporates. Second, there is a growing trend to regularly fuse strategic purchasing into a performance-based financing (PBF) discourse in ways that increasingly blur their distinctive properties and policy orientations, while perhaps too easily obfuscating potential tensions. We believe the discourse on strategic purchasing would benefit from better conceptual clarity by dissociating and prioritising its two objectives, namely: priority should be given to needs-based allocation of resources, while rewarding performance is a subsequent concern. We argue there is a need for a more thoroughgoing conceptual and empirical re-examination of strategic purchasing's priorities, its link with PBF, as well as for a wider evidence-base on what strategic purchasing tools exist and which are most appropriate for diverse contexts.

KEYWORDS

low- and middle-income countries, performance-based financing, strategic purchasing

1 | INTRODUCTION

Strategic purchasing of health services "can be defined as the transfer of revenues to providers based on information on either the health needs of the population served and/or the performance of the providers."[1] It has been promoted by the World Health Organization (WHO) and the World Bank (WB) for nearly two decades as a way to improve health system performance.[2,3] It is increasingly advanced as an approach that is necessary for progress towards universal health coverage (UHC).[4,5]

Strategic purchasing has gained popularity in recent years among global health practitioners and academics. Some partnership collaborations have begun to study the promise of strategic purchasing as a health system reform tool, such as the Health Finance and Governance Project,[6] the Resilient and Responsive Health Systems (RESYST) collaboration (see https://resyst.lshtm.ac.uk/strategic-purchasing), the Joint Learning Network for UHC (see https://www.jointlearningnetwork.org/what-we-do/#technical-initiatives) and the Strategic Purchasing Africa Resource Centre (see https://sparc.africa/). The latter three organised a joint workshop in November 2018, which focused on strategies to overcome obstacles to strategic purchasing for UHC.[7] The Finance Department of the WHO has also piloted a number of events and publications on the use of strategic purchasing,[4,5] including a webinar series on "Governance for strategic purchasing" (see https://www.who.int/news-room/events/detail/2019/06/25/default-calendar/governance-for-strategic-purchasing-implementing-results-based-financing-in-a-decentralized-setting). As for academics, a quick search on PubMed (on 18 February 2020) using the term 'strategic purchasing' found 254 references, dealing both with high-income and low- and middle-income countries—the oldest one dating back to 1982. Nevertheless, more than half of them (133 publications) were published since 2012, illustrating that strategic purchasing is receiving increased academic interest.

While we applaud the growing importance given to strategic purchasing in the UHC agenda, here we would like to explore what we see as two emerging concerns within current discussions: First, there exists a great deal of misunderstanding and conceptual unclarity around the concept of strategic purchasing and what instruments it incorporates, which is particularly felt within practitioner groups; second, there is a growing trend to regularly fuse strategic purchasing into a performance-based financing (PBF) discourse in ways that increasingly blur their distinctive properties and policy orientations, while perhaps too easily obfuscating potential tensions. What these concerns suggest is the need to better understand what strategic purchasing entails in terms of the tools and mechanisms available under its remit, more clarification regarding the prioritisation of its objectives, as well as how these priorities potentially condition PBF's role as a strategic purchasing instrument.

2 | MATERIALS AND METHODS

We conducted a targeted review of the (published and grey) literature on strategic purchasing and PBF, with a focus on the recent WHO reports, due to their normative influence on policy alignment. We critically analysed discourses found in the literature. Moreover, we conducted a rapid survey among African health systems experts, who attended a specialised course on health systems in Brussels during the summer of 2019. We conducted six individual semi-structured interviews and two focus group discussions, totalling 18 African health practitioners (five from Western Africa and 13 from Central Africa) originating from six countries. All participants were informed of the purpose of the interviews and group discussions, agreed to its use within ongoing research regarding strategic purchasing, and signed an informed consent form. Of the participants, all but one had experience in designing or implementing some form of what they thought was strategic purchasing. The aim of the interviews was to shed critical light on how strategic purchasing is understood as a health reform tool by those engaged in its use, and to examine their experience with implementation challenges. Finally, we complemented this with informal discussions with global health consultants and other African policymakers.

3 | RESULTS

3.1 | A concept that is misunderstood by many

In general terms, strategic purchasing requires responding in a thoughtful way to three sets of questions: what services to buy; from which providers; and how—the latter being justified by an acknowledgement of the fact that the various possible provider payment mechanisms are associated with varying incentives.[2,5,8] Thus, strategic purchasing notably requires switching from reimbursing services or incrementally revising line-item budgets, to choosing ex-ante what services better respond to health needs.

Various attempts to conceptualise strategic purchasing have been advanced in the literature. For instance, Cashin understood health purchasers to make strategic decisions in five areas—coverage, benefits packages and cost-sharing, contracting, provider payment and quality—and sought to explain the respective advantages and disadvantages of each provider payment method.[9] Klasa et al. identified five components associated with strategic purchasing, which captured broad normative ambitions for population health needs, citizen empowerment, government stewardship and capacity, purchaser-provider relationships and cost-effective contracting[10]—complementing the technical dimensions Cashin highlighted by suggesting potential governance components, pointing to the fact that strong governmental stewardship, as well as the capacity to monitor and audit stakeholders, is a key component of strategic purchasing.[10] More recently, a realist review developed a theoretical interpretation framework relying on two strands of theory: the economics of organisation and inter-organisational relationships. It conducted a literature review and analysed it qualitatively, focusing on the lessons most relevant to three key policy objectives associated with strategic purchasing as taken from the international health policy literature, namely: patient empowerment, government stewardship and provider performance. The review argued that "further empirical work is needed to explore how far these lessons are a practically useful guide to policy in a variety of healthcare systems, country settings and purchasing process phases."[11] That review generated a reaction from the RESYST consortium, which recommended the addition of "organisational capacity to implement complex reforms" as a key component of strategic purchasing.[12] Another recent review focused on high-income countries, which further highlighted existing confusion around the concept and what it specifically entails, concluding that "[e]xisting definitions of strategic purchasing are vague and often lack concreteness and coherence."[10]

What this demonstrates, prima facie, is that despite its growing use in the UHC discourse and beyond, there remains considerable debate about what strategic purchasing enjoins and what specific instruments should be part of its toolbox. As the above suggests, the discourse on strategic purchasing emerged in large part from the literature on health provider payment methods, which has inadvertently steered the discourse in particular directions. Moreover, the frameworks mentioned above also show that strategic purchasing is meant to embrace (or does encompass) further crucial aspects of governance (broadly including issues of policy capacity, monitoring, communication mechanisms, verification and accountable leadership), yet the reach and scope of these crucial links remain indefinite.

As a result, although there may be agreement on the need to make purchasing more strategic, there is no consensus about what a strategic purchasing approach fully entails, as it seemingly includes many possible instruments to make purchasing more 'strategic'.[8,13] To test this intuition, we interviewed 18 African colleagues about their understanding and perceptions of strategic purchasing. As anticipated, strategic purchasing is implemented in a multitude of ways within the six countries represented, with many potential mechanisms and tools identified by our respondents. These included ways to determine a package of services by a purchaser (eg, health insurer); needs-based allocation of resources (eg, to vulnerable areas or populations); target or priority-based planning (eg, programme budgeting, vertical programmes); providing incentives for quality and/or efficient use of resources; PBF; contracting service providers; joint purchase of medical products; subsidised and accessible flat rate pricing; as well as a particular mechanism in the Democratic Republic on the Congo entitled "single contract" that operated between the Ministry of Health and its development partners (which has more to do with a kind of memorandum of understanding about shared objectives than with purchasing of health services). However, our interlocutors also suggested

that strategic purchasing was close to other related concepts, such as results based management, evidence-based planning, PBF and the search for efficiency, and that there were duplications and a lack of coherence or harmonisation between the various strategic purchasing mechanisms implemented in their country. Overall, it was clear from the discussions that strategic purchasing remained a fuzzy concept, with a number of divergent views and/or misunderstandings related to what it involved and how it could be most usefully practiced.[14]

3.2 | Strategic purchasing is increasingly being equated with performance-based financing

Amongst the confusion, there seems also to be increasing links made between strategic purchasing and PBF—at least with regard to low- and middle-income country (LMIC) contexts. In Burkina Faso, for example, when the PBF programme was deemed as underperforming[15] and local authorities expressed scepticism, the World Bank responded by recasting the programme as operating within a strategic purchasing framework. The issue, however, is that national implementers have reported that they do not clearly understand the difference between the two concepts. In particular, local stakeholders have indicated that part of the confusion arises from the fact that they were told that PBF was "the purest form of strategic purchasing," but without clear-cut programme alterations (personal communication). In Benin, where PBF was considered untenable and discontinued in 2017 without evaluation,[16] a national informant expressed his concerns that some donors were "trying to bring back PBF under the disguise of strategic purchasing" (personal communication). Such conflation and confusion among field actors are fuelled by increasingly equivocal discourses on the part of donors and scholars.

However, this conflation was not always the case. Most foundational documents on strategic purchasing did not equate it with PBF, presenting PBF as only one among many options when implementing strategic purchasing. For instance, the World Health Report (WHR) 2000[2] explicitly recognised that "selective contracting and *the use of several payment mechanisms* are needed to set incentives for better responsiveness and improved health outcomes" (p. 140, italics ours). The WHR 2010[17] also mentions that "[p]aying for performance *is only one of the considerations* when allocating funds to ensure that good quality services are available to those who need them and that the system functions efficiently" (p. 76, italics ours) and that "[t]here may well be a role for payment based on performance under active purchasing, but it is likely to work better if it is part of an overall approach *that includes all the other elements*" (p. 77, italics ours).

Despite this original discourse that kept strategic purchasing and PBF as representative of distinct, yet related concepts, there is concern that more recent documents increasingly blur the lines between the two. The following extracts help to illustrate this potential slippage. To be clear, we are not claiming that these examples are a definitive indication that PBF is always equated with strategic purchasing. Instead, our aim is to merely highlight that there are increasing links being made and that further insinuations that PBF represents a "pure form" of strategic purchasing, when readily repeated, may lead non-specialists to understand PBF as relationally necessary and/or sufficient for strategic purchasing. The issue is that this may come at the cost of not considering other useful and potentially more contextually appropriate instruments.

In 2016, the WHO engaged with two communities of practice—one on financial access to healthcare and one on PBF—to organise a joint seminar on "Strategic purchasing: an emerging agenda for Africa." That seminar concluded that "moving towards strategic purchasing can start with 'small' incremental measures. For example, PBF can be an entry point towards more strategic purchasing, if well integrated and designed to be scaled up."[18] Later that year, the WHO's director for health financing also presented PBF as an entry point for strategic purchasing.[19] Another health financing working paper suggested that progress towards UHC involved a "move towards strategic purchasing, which seeks to align funding and incentives with promised health services."[4] A WHO staff publication asserted that "[f]irst and foremost, P4P [pay-for-performance] is a strategic purchasing tool …."[20] Another one states that "facility financial autonomy supported by pay-for-performance is key for ensuring progress towards strategic

purchasing."[21] Even more recently, the link between PBF and strategic purchasing was solidified via a claim that under passive purchasing (the opposite of strategic purchasing) there are "few if any financial incentives for providers to do better."[5]

Furthermore, the intermarriage of PBF and strategic purchasing is also fuelled within the PBF literature, which has increasingly presented PBF as a preferred tool to implement strategic purchasing. For example, World Bank consultants state that PBF programmes "use strategic purchasing of services to expand coverage and promote quality …."[22] Witter et al. examined how (and whether) PBF strengthens strategic purchasing of health in three countries.[23] Gautier et al. explain that "[w]hen the concept of 'strategic purchasing' came into the debate in late 2016, PBF offered to operationalise that concept… PBF thus got linked to strategic purchasing, reportedly thanks to internal framing activities done by individual [diffusion entrepreneurs] within the World Health Organization."[24]

A related discourse trend observed in recent years is the demonization of input-based financing, which has potential to automatically nudge strategic purchasing decisions toward PBF output-based models regardless of contextual fit or strong evidentiary support. As part of this discourse, there have been increasing calls by international consultants and local health managers that countries should "obviously" shift to output-based financing because "input-based financing does not work" (personal communication) or that output-based financing has already "proven its success" against traditional financing models (p. 5).[25] This opinion often cites an evidence-base that remains disputed and indeterminate, yet remains fuelled by like-minded global health experts. For instance, a report on strategic purchasing, organised by WHO, affirmed that PBF "… can also act as a catalyst for health system reform" and urges countries to "… move away from pay for input to pay for output."[26] The 2019 WHO course on health financing in French asserts that the instruments for strategic purchasing ("how to buy") include "switching to paying for outputs" as well as "disincentives and incentives for certain services."[27] More polemically, a recent blogpost disseminated in the Community of Practice "Health Financing in Africa" asserted that PBF was "proposed in different parts of the world to end the suffering, corruption and inefficiencies that derive from input-based policies and dysfunctional social systems."[28] The concern here is not that output-based instruments should not be part of the discourse, they of course should. The concern is that they should not be so readily the only discourse available, particularly when there remains considerable debate about which models best support sustainable health system strengthening.

4 | DISCUSSION

The discourse extracts presented above make it easier to understand the potential for confusion, since the aforementioned language associated with strategic purchasing could easily be swapped for common rationales used to explain PBF, which advances output-based payments and targeted service incentivisation. This is especially so when repeated by knowledgeable experts with presumed epistemic authority in consultations with non-specialists,[29-31] where such rudimentary associations might lead stakeholders to utilise PBF as the primary heuristic to achieve strategic purchasing.

More cynical minds might wonder whether this increased association between strategic purchasing and PBF represents an ideational effort to rebrand PBF under strategic purchasing's more popular moniker,[32] thus giving PBF refreshed, and potentially unfounded, epistemic authority. This perception of a potential rebranding was certainly the case in our field observations in Benin and Burkina Faso. If this is so, then this confusion and rebranding may benefit PBF promoters, since it allows for positive associations with strategic purchasing, which currently enjoys a discourse that argues that "strategic purchasing is necessary to reach UHC." Nevertheless, the reverse is not immediately true. Rather, perceptions of strategic purchasing could be harmed by the negative view PBF has among many stakeholders, including in LMICs.[33] As a result, this conjoining of PBF with strategic purchasing has the unwanted potential to contaminate legitimate attempts to encourage countries to render their health service purchasing more strategic in the pursuance of UHC. The problem also raises that a close assimilation could unwittingly limit reform options in consequential ways, since PBF may over encourage a focus on aspects of provider payment mechanisms

(rather than aspects of broader resource allocation), or animate a narrow vision of performance as output performance (in practice, PBF programmes generally focus on a limited number of output indicators, complemented by quality measures, while tending to pay little attention to equity and efficiency).[34-36]

In response, we believe the discourse on strategic purchasing would benefit from better conceptual clarity by dissociating and prioritising its two objectives as presented at the beginning of this paper. Namely, if strategic purchasing consists in "the transfer of revenues to providers based on information on either the health needs of the population served *and/or* the performance of the providers" (italics ours),[1] then priority should definitely be given to the former. Indeed, it would make little sense to reward or incentivise provider performance for non-priority services, which thus already implicitly assumes an inherent prioritisation. Furthermore, the importance of responding to populations' priority health needs as the primary objective of strategic purchasing is confirmed by the African health practitioners we interviewed.[14] Therefore, in our view, rewarding performance is most useful only once the resource allocation system has managed strategically to identify the right services and fund them in such a way that they are made affordable for the poor. This may very well be satisfied via PBF programming. Yet, this should not be unreflectively assumed, since prioritised services may also be perfectly satisfied without using PBF as an "entry point," namely via a global budget based on needs assessments or a capitation system, which may be more appropriate to ensure equity and (allocative and technical) efficiency.[37]

What is being suggested here is that the numerous possible tools to make purchasing more strategic should not be ignored due to PBF's lexiconic and ideational hegemony. As the World Bank itself acknowledges, "it is not yet clear how forms of strategic purchasing can be institutionalised in countries with limited technical capacities."[38] What this suggests, prima facie, is that strategic purchasing in LMICs is nascent in its evidence-base, with important concerns about the suitability and acceptability of its practical tools. In particular, although the PBF community increasingly argues PBF's potential in terms of resource allocation (compared to its motivation function),[39] when touting the promises of PBF as a strategic purchasing mechanism, there still remains very little evidence to indicate that PBF is the most efficient way of doing so.

To sum up, while we agree that publicly purchased health services should respond to society's needs and patients' expectations, and thus generally endorse strategic purchasing as a guiding principle, we also believe it unwise to increasingly equate it as merely a form of PBF (or vice versa). Part of this confusion relates to a growing need for a more thoroughgoing conceptual and empirical re-examination of strategic purchasing's priorities, its link with PBF as merely one potentially useful instrument, as well as a need for a wider evidence-base on what strategic purchasing tools exist and which are most appropriate for diverse contexts.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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